DOCUMENT RESUME

ED 148 044 EC 103 085

AUTHOR	Reggio, Kathryn D.; And Others
TITLE	Sociological Health Problems: Individualized Incentive Program Modules for Physically Disabled Students for Grades Kindergarten Through Twelve. Teacher's Edition.
INSTITUTION	Human Resources Center, Albertson, N.Y.
SPONS AGENCY	Office of Education (DHEW), Washington, D.C.
BUREAU NO	H233556
PUB DATE	77
GRANT	OEG-0-73-7065
NOTE	111p.; For related information, see EC 103 086 - EC 103 088 and EC 101 865
AVAILABLE FROM	Human Resources School, Albertson, New York 11507 ($15.95 for the 5 modules)
EDRS PRICE	MF-$0.83 Plus Postage. HC Not Available from EDRS.
DESCRIPTORS	*Curriculum Guides; *Drug Education; Elementary Secondary Education; Health Activities; *Health Education; *Physically Handicapped; Smoking

ABSTRACT

Presented is the second in a series of modules from a project to adapt the New York State Health Education curriculum for physically disabled students (grades K-12). An introductory section to the volume on sociological health problems provides definitions and summaries about nine physically disabling conditions and briefly considers activities at the Human Resources School (Albertson, New York) related to sociological health problems. Modules are described for grades 4-9 (developing a positive self concept and smoking and the health of the disabled student), grades 7-9 (developing alternatives to the use of drugs and developing self confidence through assertiveness); and grades 10-12 (learning and service to others through a combined drug education project). Each module contains background information specific to the topic for nine physically disabling conditions. Also included are listings of concepts, student activities, and student self evaluations. Among four appendixes are lists of additional resources and an annotated bibliography for specific disabilities. (CL)

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Sociological Health Problems

INDIVIDUALIZED HEALTH INCENTIVE PROGRAM MODULES FOR PHYSICALLY DISABLED STUDENTS FOR GRADES KINDERGARTEN THROUGH TWELVE

TEACHER'S EDITION

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1977

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FOREWORD

I am delighted to congratulate the distinguished members of the Human Resources School faculty whose efforts and dedication over the last three years have culminated in the publication of these Health Education modules.

Health Education is one of the most important components of any school's curriculum. It is not enough for us to prepare our children to enter college or the world of work; we must prepare them to enter the arena of life equipped with a full understanding of their bodies and minds. Topics like mental health, family life, safety, and nutrition are as important to the growing disabled child as they are to the able-bodied youngster.

My responsibilities as Chairman of the White House Conference on Handicapped Individuals have given me a clear perspective on the status of the severely disabled in America's communities. Throughout the nation, states are enacting legislation to mainstream disabled children into neighborhood public schools. The modules will go a long way in preparing teachers in public schools in New York State and throughout the country to provide handicapped children with a proper health education.

Henry Viscardi, Jr.
Human Resources Center

ACKNOWLEDGMENTS

I would like to acknowledge with special appreciation the extraordinary contributions of the project team: Josephine Davidson, Donna Shoeltz, Marilyn Hawkins, and Dr. Leon Greenspan.

Special recognition goes to the dedicated faculty members who tried out and contributed to the activities: Carol D'Ambrosio, Kathy Finnigan, Susan Gordon, Edna Humbert, Patricia Iannucci, Sheila Mohrman, Barbara Ringewald, Eileen Singleton, Barbara Steinberg, and Phyllis Riefberg.

Gratitude is expressed to our guest speaker-consultants who generously shared their experiences and advice with our students: Dr. Ronald Friedman, Dr. Marie Meier, Dr. Emanuel Plesent, and Daniel Sullivan.

Special appreciation is extended to the research librarian, Ruth Velleman, for assistance in obtaining many specialized materials used by the project team and the students.

Sincere thanks to the capable project secretary, Susan Kurtzke.

For invaluable guidance in the technicalities of developing our project, I wish to add a note of appreciation to Dr. Edwin Martin, Dr. Max Mueller, Melville Appell, and Mel McNeill of the Bureau of Education for the Handicapped in Washington.

The cooperation of the New York State Education Department and the Department of Health and Drug Education enabled us to build further on their excellent Health Education curriculum.

Final gratitude is expressed to our wonderful administrators during the course of the project, Richard Switzer, Dr. Henry Bormann, and Robert Gibney.

Kathryn D. Reggio
Project Director

TABLE OF CONTENTS

Foreword i

Acknowledgments ii

Introduction 1

Definitions of Disabilities 4

Summary of Information about Disabilities 6

Activities at Human Resources School Related to Sociological Health Problems 17

Evaluation 20

MODULES:

Sociological Health Problems – Grade 4-9 25
- I. Developing a Positive Self-Concept 26
  - A. Coping With Feelings 26
  - B. Handling Frustrations and Solving Problems 27
  - C. Recognizing One's Own Abilities 29
  - D. Communicating 29
- II. Smoking and the Health of the Disabled Student 30

Sociological Health Problems – Grade 7-9 25
- III. Developing Alternatives to the Use of Drugs 32
- IV. Developing Self-Confidence through Assertiveness 33

Sociological Health Problems – Grade 10-12 35
- I. Sharing and Service to Others through a Combined Drug Education Project 38
  - A. Sharing Factual Information about Drugs and Alcohol with Younger Students 38
  - B. Explaining Possible Reactions from Mixing Medications with Drugs or Alcohol 38
  - C. Teaching How Drug Abuse Could Increase Disability Problems 38
  - D. Helping Younger Students to Develop Personal Responsibility 38

Appendix

New York State Curriculum Topics 43

Helpful Teacher References Used by the Health Project Committee 46

Sources of Additional Information 48

Annotated Bibliography for Specific Disabilities 49

INTRODUCTION

The purposes of this project are to adapt the New York State Health Education curriculum to the special needs of physically disabled students in grades kingergarten through twelve, and to organize educational information about physical disability.

This module, Sociological Health Problems is one of the five areas or strands of health education which have been adapted. The others are Safety and Survival Education, Physical Health, Mental Health and Family Life Education, and Environmental and Community Health.

Under each topic of the New York State Health Education curriculum, individualized health incentive program modules have been adapted for students having the physical disabilities included at Human Resources School.

To deal with the mental health needs of children in the school whose disabilities included 33 different handicaps or diseases, this adapted curriculum considers them under nine broad categories of health problems.

1. Lack of function of the involuntary nervous system
2. Diminution or absence of feeling in the extremities, paralysis, wearing braces, confinement to a wheelchair, poor cordination
3. Generalized muscle weakness
4. Arm and joint immobility
5. Prosthetic limbs
6. Fragility of bones
7. Diminutive size
8. Poor circulation
9. Inability to control bleeding

Each health problem is represented by the underlined disability listed next to it, but it is felt that the modules could also apply to the other disabilities which are listed with the underlined disability.

Thus, teachers and students could use the activities of the module for any of the other disabilities in the same category.

This program builds in the incentive by incorporating student self-evaluation activities and a number of motivational procedures. It is believed that student self-evaluation based on individually chosen relevant learning activities provides the greatest incentive for learning and leads to a stronger desire to improve.

The three columns on each right-hand page are directed toward the student, and the student activities and self-evaluations are written in terms of behavioral objectives. Only the teacher's module contains the background information on the left-hand page.

Dysautonomia

Spina Bifida, Post-poliomyelitis, Quadraparesis, Paraplegia, Hemiplegia, Spastic Paraplegia, Dystonia, Legg-Calve-Perthes Disease, Seizure Disorders

Muscular Dystrophy, Amyotonia Congenita, Kugelberg-Welander Disease, Charcot-Marie-Tooth Disease

Arthrogryposis, Rheumatoid Arthritis

Congenital Amputee, Limb Deformities

Osteogenesis Imperfecta

Achondroplasia

Congenital Cardiac Conditions, Rheumatic Heart Disease

Hemophilia, Thalassemia, Sickle Cell Disease

This curriculum is conceived of as separate modules for each topic. It has been printed and bound in two forms – the first, a limited number of the separate modules, and the second with the modules combined into bound booklets. This second form was necessitated by budgetary limitations. Human Resources accepted the responsibility of sharing the finished product with all the participating agencies, school districts, and consultants who cooperated with the committee during the project's development. This was possible only by binding the modules as booklets instead of packaging each one separately in its own packet or binder.

The suggested method of use is to have each student individually choose the topic he finds pertinent and follow the related activities and student self-evaluations.

The student's modules can be printed without the teacher background information.

The activities were designed for use with the severely physically disabled students at Human Resources School. The school has certain decided advantages for implementing a special health education curriculum:

1. A number of students with similar disabilities who can work together on related activities.

2. Accommodated rooms, furniture, shelves, elevators, automated doors, etc.

3. Specially adapted: library, swimming pool, gymnasium, stage, auditorium, cafeteria, art room, toilets, open classroom, home economics room, greenhouse.

4. Services of a physician, school-nurse-teacher, practical nurse, physical therapist, dental clinic, orderly, psychologist, speech therapist, and 200 volunteers.

5. Equipment: motorized wheelchairs, rolling litters, rolling stretchers.

The staff of the school has found that students who might otherwise be homebound can be physically accommodated. When the physical accommodations are provided, the intellectual and social needs can be taken care of. The health project committee does believe that, although it was developed in a special setting, this health curriculum also has a wider application to schools or classes having only a few students with physical disabilities.

Although the average school may not have all the suggested accommodations, the background information pages tell the teachers what their students with certain disabilities might be expected to do and what special needs must be considered in their health education.

School districts wishing to conform to the law mandating equal opportunity for education for the handicapped may be able to adapt their facilities on a smaller scale as the needs arise.

In inaugurating a health curriculum at Human Resources School, a great deal of time had to be spent on the most basic general material. For a number of reasons, the students at Human Resources School knew less about health than the average student.

The opportunity to spend more time than the minimal amount required by the state had never presented itself before. Students had missed a great deal of both academic and health education through long absences and hospital stays. The fact that someone else had had to perform a great deal of their physical care had made it unnecessary to learn basic hygiene or health habits. This situation had also delayed or discouraged the development of individual initiative.

The curriculum in mental health recommended for physically disabled students and followed as a basic course at Human Resources School includes the content topics given in the New York State Health Education Curriculum. We feel that they are excellent. As a matter of fact, our experience has been that our students needed a great deal more time devoted to the content than was required by the state – and we did allow the necessary time.

The basic assumption at Human Resources School is that our students are normal young people who happen to have a disability. They have all the physical, emotional, and intellectual needs of other normal students, plus some additional ones engendered by their disability. We therefore regard our curriculum as an addition to the New York State curriculum, not a replacement, and recommend that both the basic course of study for New York State, and the units developed at Human Resources School be used together.

A curriculum in health education for physically disabled, intellectually average students should include all the knowledge and topics in the regular curriculum so that disabled students with limited experience will be able to understand the standards of the average, physically "normal" person and can

realize how much of their own health and bodily activity is the same as that of the average person.

Because of their limited experience or sheltered environment, some physically disabled students need special understanding about how and why regular health habits apply to them.

In addition, physically disabled students need to learn the practicalities of dealing with special health problems related to or resulting from their disability. As a matter of fact they need to learn what their disability is, and to know how to maintain or improve their health status.

Conclusion: They need more time for health education. The recommendation is for six half-year programs in junior-senior high school on a 3-year cycle of topics, 3 for junior high and 3 for senior high.

In each of the elementary grades, integration with other subjects is recommended on a three-times-a-week basis.

DEFINITIONS OF DISABILITIES

DYSAUTONOMIA – Genetic condition found in Jewish children of Eastern European extraction. Affects the function of the autonomic (involuntary) nervous system. Skeletal involvement, such as scoliosis, often occurs.

SPINA BIFIDA – Congenital (existing from birth). Defect in the vertebral column characterized by the presence of a myelomenigocele (protrusion of the spinal cord and membrane covering it) both of which should normally be covered by vertebrae. Below the level of the defect, the child has diminished sensation of lower extremities, varying degrees of paralysis, and is incontinent of bowel and bladder.

POST-POLIOMYELITIS – Poliomyelitis is an infectious disease affecting the motor cells in the spinal cord resulting in weakness or paralysis. There may be subsequent atrophy of groups of muscles, ending in contraction and permanent deformity.

QUADRIPLEGIA – Paralysis affecting all four extremities.

PARAPLEGIA – Paralysis of lower portion of body – below waist. May be traumatic, infectious, or congenital.

HEMIPLEGIA – Paralysis on one half of the body – one leg and arm on one side.

SPASTIC PARALEGIA – Spastic paralysis occuring in early childhood. May be traumatic, infectious or congenital. May involve cerebral hemorrhage before birth, or abnormal, involuntary movements of the muscles.

DYSTONIA – Musculorum Deformans – Chronic motor disorder. May be hereditary. Marked by abnormal movements of the muscles.

ATAXIA – Generalized term – usually involves poor coordination, lack of dexterity, unsteady gait, and slow speech. May be congenital or acquired.

FRIEDRICH'S ATAXIA – Progressive paralysis of lower limbs, ataxia and speech impairment.

LEGG-CALVE-PERTHES DISEASE – A disease of the head of the thigh bone which causes a degeneration and necrosis. This is followed by regeneration or recalification. (hip area). Most often affecting boys between four and eleven years of age.

CEREBRAL PALSY – The most common terminology used for children whose symptoms are similar to those with Ataxia. However, there is also a disorder in movement, posture, and coordination related to non-progressive damage to the brain.

MUSCULAR DYSTROPHY – Hereditary disorder transmitted by females but affecting mostly males. Progressive generalized weakness of the voluntary muscles. Non-contagious, chronic wasting which leads to increasing infirmity, and ultimately death.

AMYOTONIA CONGENITA (Oppenheim's Disease) – Born with generalized poor muscle tone. "Floppy" With or without muscle weakness. A descriptive term for many conditions. (Spinal Atrophy)

KUGELBERG-WELANDER DISEASE – A Neuro-muscular disorder. Weakness and atrophy (wasting) of muscles; slowly progressive.

CHARCOT-MARIE-TOOTH DISEASE – Peroneal muscular atrophy. Hereditary neuro-muscular disorder. Slowly progressive muscle atrophy and weakness, starting in the legs.

ARTHROGRYPOSIS MULTIPLEX CONGENITA – A congenital, non-progressive condition in which the tissues at some or all the joints are stiff and fibrous holding the limbs rigid in flexed or extended positions. The joint malformations result from immobilization of the developing embryo from any of a variety of causes which prevent normal spontaneous movements.

RHEUMATOID ARTHRITIS – Disease in which inflamed joints are often accompanied by pain, swelling, and limitations in joint movement and weakness of muscles.

CONGENITAL AMPUTEE – Children who are born with total or partial absence of a limb. (Also called reduction deformity)

LIMB DEFORMITIES – Distortion or disfigurement of a limb.

OSTEOGENESIS IMPERFECTA – This condition, also known as "Brittle Bones", is an inherited disorder of development in the skeleton in which the calcium content is far below normal. The bones are excessively thin and subject to multiple fractures following even mild trauma. Children are usually smaller in stature because fractures often occur in the long bones of lower extremities. Congenita: born with abnormalities and often many fractures. Tarde: Condition often not seen until the child starts to walk. Then fractures occur.

ACHONDROPLASIA – Congenital, frequently hereditary disorder in the conversion of cartilage to bone. Because of this, the growing ends, or epiphyses, of the long bones of the limbs, are affected, and inadequate growth results in a type of dwarfism. Short extremities, but well proportioned body. Lordosis (curvature of spine) often occurs, too.

CONGENITAL CARDIAC CONDITIONS – Born with a defect of the heart. This may involve a defect of the valves or it may involve the great vessels. Some of these can be corrected by surgical procedures.

RHEUMATIC HEART DISEASE – Injures the endocardium, the valve, or the muscle fibers. The valves may lose their original efficiency, so that passage of blood is hindered.

HEMOPHILIA – Hereditary disorder transmitted by females but usually affecting only males. An abnormality in blood coagulation resulting in prolonged coagulation time and lowered prothrombin (clotting factor II) consumption.

THALASSEMIA – Hereditary; genetically determined, chronic anemia, causing poor bone growth, fatigability, nose bleeds, and low grade fever.

SICKLE CELL DISEASE – A hereditary, genetic condition of the blood which affects the red blood cells causing them to be malformed like a sickle. Occurs most often in blacks. Characterized by arthralgia, acute attacks of abdominal pain, and ulcerations of the lower extremities.

SUMMARY OF INFORMATION ABOUT DYSAUTONOMIA (1)

For the general understanding of teachers or aides who might be working with a student with this disability, we have compiled a general summary from the records of the students at Human Resources School. This information represents a variety of findings, since each student has his own physician and may have attended different hospitals or rehabilitation centers.

Therefore, two important points must be noted. One is that each child is different, and so is the severity of his disability. The other is that medical procedures and recommendations are constantly advancing and changing, and these findings represent only a summary of the past.

Dysautonomia – Genetic condition found in Jewish children of Eastern European extraction. Effects function of autonomic (involuntary) nervous system. Skeletal involvement, such as scoliosis, often occurs.

SYMPTOMS:

Lack of tears

Insensitivity to pain

Vomiting

Blotching of skin

Unstable temperature – fluctuations unrelated to infections

Unstable blood pressure

Emotional instability

Delayed development (Riley-Day Syndrome: late motor development, floppy appearance, tendency to vomit, some degree of pseudo-retardation due to lack of experience and exposure early in life)

HOSPITALIZATIONS AND TREATMENTS:

Nerve biopsies (nerves have areas without normal bundles)

Eyes: histamine and mecalin

SPECIAL PROBLEMS NOTED AND RECOMMENDATIONS MADE BY DOCTORS:

PROBLEMS:

Corneal ulcers

Gastro-intestinal problems

Bladder problems – incontinence of urine

Skeletal system: scoliosis, deformities of long bones, embarrassment of respiratory system

Tendency to become fatigued easily because of weaker muscles, diminished respiratory function, lower endurance

Sleep often interrupted by URI or vomiting

Short life expectancy – death possible from aspiration, cardiac or respiratory failure, high fever, fluctuating blood pressure

RECOMMENDATIONS:

Therapy: derotation exercises for scoliosis, ROM and active assistive exercises, breathing exercises

Back brace if scoliosis is severe

Artificial tears to be administered several times daily

Quiet firmness on the part of teachers and others in authority; need for defined controls and limits

SUMMARY OF INFORMATION ABOUT SPINA BIFIDA MANIFESTA (2)

For the general understanding of teachers or aides who might be working with a student with this disability, we have compiled a general summary from the records of the students at Human Resources School. This information represents a variety of findings, since each student has his own physician and may have attended different hospitals or rehabilitation centers.

Therefore, two important points must be noted. One is that each child is different, and so is the severity of his disability. The other is that medical procedures and recommendations are constantly advancing and changing, and these findings represent only a summary of the past.

Spina Bifida Manifesta – Congenital (existing from birth). Defect in the vertebral column characterized by the presence of a myelomeningocele (protrusion of the spinal cord and membranes covering it) both of which should normally be covered by vertebrae. Below the level of the defect, the child has diminished sensation of lower extremities, varying degrees of paralysis, and is incontinent of bowel and bladder.

SYMPTOMS:

Myelomeningocele present at birth

Sensory loss and motor loss

Bowel and bladder incontinence

Hydrocephalus (enlargement of the head caused by improper circulation and absorption of cerebrospinal fluid) may develop any time after birth.

HOSPITALIZATIONS AND TREATMENTS NOTED IN RECORDS:

Closure of myelomeningocele shortly after birth

Shunt procedure to redirect cerebrospinal fluid into the heart, where it can circulate with the blood and reduce the possibility of hydrocephalus.

Periodic shunt revisions later in life

Periodic urological check-ups

SPECIAL PROBLEMS NOTED AND RECOMMENDATIONS MADE BY DOCTORS:

PROBLEMS:

Occasional tenderness at area of myelomeningocele closure

Development of decubitus ulcers on buttocks

Pressure sores from braces

Development of lower extremity deformities

Urinary tract infections

RECOMMENDATIONS:

Therapy: ROM, PRE for uppers, ambulation training with appliances, swimming

Brace changes

Surgical procedures to allow ambulation without braces

Treatment of decubitus ulcers

SPECIAL PROBLEMS NOTED AND RECOMMENDATIONS MADE BY PARENTS:

Change in behavior after shunt revisions

Embarrassment at bowel and bladder incontinence

Embarrassment at wearing orthopedic shoes (noted by teacher)

SUMMARY OF INFORMATION ABOUT MUSCULAR DYSTROPHY (3)

For the general understanding of teachers or aides who might be working with a student with this disability, we have compiled a general summary from the records of the students at Human Resources School. This information represents a variety of findings, since each student has his own physician and may have attended different hospitals or rehabilitation centers.

Therefore, two important points must be noted. One is that each child is different, and so is the severity of his disability. The other is that medical procedures and recommendations are constantly advancing and changing, and these findings represent only a summary of the past.

Duchenne Muscular Dystrophy – Hereditary disorder transmitted by females but affecting mostly males. Progressive generalized weakness of the voluntary muscles. Non-contagious, chronic wasting which leads to increasing infirmity, and ultimately death.

MEDICAL LISTING OF EIGHT STAGES OF FUNCTIONAL ABILITY

1. Ambulates with waddling gait and marked lordosis. Elevation activities adequate (climbs stairs and curbs without assistance).
2. Ambulates with waddling gait and marked lordosis. Elevation activities deficient (needs support for curbs and stairs).
3. Ambulates with waddling gait and marked lordosis. Cannot negotiate curbs or stairs, but can achieve erect posture from standard height chair.
4. Ambulates with waddling gait and marked lordosis. Unable to rise from a standard chair.
5. Wheelchair-independence: Good posture in the chair, can perform all activities of daily living from wheelchair.
6. Wheelchair-dependence: Can roll chair, but needs assistance in bed and wheelchair activities.
7. Wheelchair-dependence-and back support: Can roll the chair only a short distance, needs back support for good wheelchair position.
8. Bed Patient: Can do no activities of daily living without maximum assistance.

25

SUMMARY OF FINDINGS FROM SCHOOL RECORDS

For the general understanding of teachers or aides who might be working with a student with Muscular Dystrophy we have summarized the findings of the records of our 34 students who have Muscular Dystrophy.

EARLY STAGES–

SYMPTOMS–

Ambulates with moderate amounts of waddling and lordosis (bending backwards) with a heel-toe pattern

Ability to walk on toes but not on heels

Need to use rail or have assistance in going up stairs or climbing a curb

Complete independence in all activities of daily living

Deep tendon reflexes absent except for Achilles jerk

Normal range of motion except for tight heel cords

Bilateral hypertrophy of the calf

Tendency to fall frequently

SPECIAL PROBLEMS NOTED AND RECOMMENDATIONS MADE BY DOCTORS

Encouragement to ambulate as much and as long as possible to prevent progression of deformities

Therapy–Active assistive exercies for upper extremities, exercises for trunk musculature, ROM (Range of Motion) of hips, knees, and ankles. All to prevent later deformities and to help maintain present level of function.

Lengthening of the heel cord and transplanting of tibial dorsum to allow ambulation for a longer period of time. (Can ambulate with braces or cast one week following surgery.)

MIDDLE STAGES–

SYMPTOMS–

Increased tendency to fall and inability to get up after falling

Final confinement to a wheelchair and dependence for activities of daily living except for feeding self and writing

Development of flexion contractures of both hips and knees and equinovarus deformity of ankles.

Severely limited range of motion in heel cord

Development of scoliosis (curvature of the spine)

Absence of deep tendon reflexes except for achilles jerk

Tendency to obesity

SPECIAL PROBLEMS NOTED AND RECOMMENDATIONS MADE BY DOCTORS–

Continuation of therapy to maintain level of function and prevent further deformities

Sometimes braces to prevent deformities

Wheelchair when ambulation is no longer possible

Diet to control obesity

Disruptive behavior in school sometimes noted by parents and teachers

LATER STAGES–

SYMPTOMS–

Complete dependence in all activities of daily living

Inability to feed self or write as musculature of wrists and hands decreases

Round facial appearance with involvement of muscles of mastication (chewing)

Complete absence of deep tendon reflexes

Progression of hip, knee and ankle deformities

Tendency to obesity

SPECIAL PROBLEMS NOTED AND RECOMMENDATIONS MADE BY DOCTORS–

Appliance to aid in writing and feeding self

Plastic sitting corset to prevent progression of scoliosis

Electric wheelchair

Diet to control obesity

Comfort aids, particularly specially made cushions to prevent pressure sores on buttocks

HOSPITALIZATIONS NOTED IN RECORDS–

Sometimes surgery for lengthening of heel cord (early stages)

Respiratory infections (later stages)

MEDICAL TREATMENTS NOTED IN RECORDS–

Surgical lengthening of the heel cord and transplanting of the tibial dorsum to allow ambulation for a longer period of time

Inhalation therapy

TESTS NOTED IN RECORDS–

Muscle biopsy, enzyme studies, etc. to determine carrier

Blood tests of parents to determine if disability is result of mutation or sex-linked characteristic

SUMMARY OF INFORMATION ABOUT ARTHROGRYPOSIS MULTIPLEX CONGENITA (4)

For the general understanding of teachers or aides who might be working with a student with this disability, we have compiled a general summary from the records of the students at Human Resources School. This information represents a variety of findings, since each student has his own physician and may have attended different hospitals or rehabilitation centers.

Therefore, two important points must be noted. One is that each child is different, and so is the severity of his disability. The other is that medical procedures and recommendations are constantly advancing and changing, and these findings represent only a summary of the past.

Arthrogryposis Multiplex Congenita – A congenital, non-progressive, condition in which the tissues at some or all the joints are stiff and fibrous, holding the limbs rigid in flexed or extended positions. The joint malformations result from immobilization of the developing embryo from any of a variety of causes which prevent normal spontaneous movements.

SYMPTOMS:

Underdeveloped due to basic disability; generalized underdevelopment of muscles and resultant muscle weakness

Absence of deep tendon reflexes

From birth – Flexion deformities of the hips, knees, wrists, toes; deformities of feet; dislocated hips

HOSPITALIZATIONS AND TREATMENTS:

Surgery to correct flexion deformities

Heel cord lengthenings and tissue releases

Bone fusions

Casting of hand to improve function (done when young)

SPECIAL PROBLEMS NOTED AND RECOMMENDATIONS MADE BY DOCTORS:

PROBLEMS:

Development of scoliosis

Frequent abdominal complaints due to ulcers or ulcerated colitis (young adults)

Little functional use of hands – need for assistance in ADL's

RECOMMENDATIONS:

Braces – standing and ambulation with appliances if possible

Sitting corset for scoliosis (to prevent further progression)

Orthopedic devices for feeding and writing

No contra-indication for swimming

Therapy: Range of motion for all joints; active assistive exercises for uppers

Wheelchair for distance if necessary

SPECIAL PROBLEMS NOTED AND RECOMMENDATIONS MADE BY PARENTS:

Assistance for ADL's

Daily therapy at home

Sitting corset difficult to handle

Pressure sores from braces

Rheumatoid Arthritis – Disease in which inflamed joints are often accompanied by pain, swelling, and limitations in joint movement and weakness of muscles.

SYMPTOMS

EARLY STAGES

Fatigue, muscular stiffness, loss of appetite and weight, cold hands and feet, swelling of joints, nodules on skin.

LATER STAGES

Loss of joint motion resulting in flexion deformities and limitation in range of movement.

HOSPITALIZATIONS AND TREATMENTS

PHYSICAL THERAPY – ROM, active assistive exercises, progressive resistive exercises

Possible splinting of hands or other surgical measures

DRUGS – Aspirin, steroids (group of drugs related to cortisone which may be discontinued because of undesirable side effects), gold salts, and antimalarials (may bring about remissions after several months of treatment).

SPECIAL PROBLEMS NOTED AND RECOMMENDATIONS MADE BY DOCTORS:

PROBLEMS:

Limitation in ADL, even restricting feeding and writing in some cases

RECOMMENDATIONS:

Diet, posture, avoidance of colds and dampness

No contra-indication for swimming

SUMMARY OF INFORMATION ABOUT CONGENITAL AMPUTEES (5)

For the general understanding of teachers or aides who might be working with a student with this disability, we have compiled a general summary from the records of the students at Human Resources School. This information represents a variety of findings, since each student has his own physician and may have attended different hospitals or rehabilitation centers.

Therefore, two important points must be noted. One is that each child is different, and so is the severity of his disability. The other is that medical procedures and recommendations are constantly advancing and changing, and these findings represent only a summary of the past.

Congenital Amputee – Children who are born with total or partial absence of a limb. (Also called reduction deformity).

HOSPITALIZATIONS AND TREATMENTS:

Depending on extent of deformity, prosthetic limbs are fitted.

Sometimes a surgical procedure may be done to facilitate fitting of a prosthetic.

As the child grows, new fittings are necessary so there is a possibility of repeated hospitalizations throughout their lives.

SPECIAL PROBLEMS AND RECOMMENDATIONS MADE BY DOCTORS:

Make sure area of limb that fits into prosthesis is protected from skin breakdown.

When prosthesis gets too small rubbing can cause skin irritation.

Use these prostheses.

SUMMARY OF INFORMATION ABOUT OSTEOGENESIS IMPERFECTA (6)

For the general understanding of teachers or aides who might be working with a student with this disability, we have compiled a general summary from the records of the students at Human Resources School. This information represents a variety of findings, since each student has his own physician and may have attended different hospitals or rehabilitation centers.

Therefore, two important points must be noted. One is that each child is different, and so is the severity of his disability. The other is that medical procedures and recommendations are constantly advancing and changing, and these findings represent only a summary of the past.

Osteogenesis Imperfecta – This condition, also known as "Brittle Bones", is an inherited disorder of development in the skeleton in which the calcium content is far below normal. The bones are excessively thin and subject to multiple fractures following even mild trauma. Children are usually smaller in stature because fractures often occur in the long bones of the lower extremities

Congenita: born with abnormalities and often many fractures.

Tarde: condition often not seen until the child starts to walk. Then fractures occur.

SUMMARY OF FINDINGS FROM SCHOOL RECORDS:

For the general understanding of teachers or aides who might be working with a student with Osteogenesis Imperfecta, we have summarized the findings of the records of our 14 students who have Osteogenesis Imperfecta.

SYMPTOMS:

Eyes – Blue Sclera

Teeth translucent with pearl-like appearance

Healed fractures, primarily of lower extremities

Bowing of long bones (Shepherd's Crook)

Short structure – disproportion between trunk and extremities due to frequent fractures

Megacephaly only apparent because of trunk size as seen in proportion to extremities

Generally underdeveloped physical appearance

Infantile behavior due to protection necessitated by brittle bones – infantile behavior in young children.

HOSPITALIZATIONS:

Fractures – some set in doctor's office; others requiring surgery

Rodding of femur and tibia to aid in the prevention of further fractures (some cases)

MEDICAL TREATMENTS NOTED IN RECORDS:

Calcitonin – Some cases

Therapy (various depending on each child)

A. Swimming
B. Ambulation training if possible
C. Exercise for ROM, muscle strength, etc.

SPECIAL PROBLEMS NOTED AND RECOMMENDATIONS MADE BY DOCTORS:

Limitations set on Physical Education Activities

Fear of doctors and examinations

Immaturity and infantile behavior

Recommendations for therapy, rodding procedures, change in appliances or wheelchairs

SPECIAL PROBLEMS NOTED AND RECOMMENDATIONS MADE BY PARENTS:

Fear of doctors

Fear of falling

Fear of fractures

Discomfor while in SPICA

Fear of being handled by people other than parents

SUMMARY OF INFORMATION ABOUT ACHONDROPLASIA (7)

For the general understanding of teachers or aides who might be working with a student with this disability, we have compiled a general summary from the records of the students at Human Resources School. This information represents a variety of findings, since each student has his own physician and may have attended different hospitals or rehabilitation centers.

Therefore, two important points must be noted. One is that each child is different, and so is the severity of his disability. The other is that medical procedures and recommendations are constantly advancing and changing, and these findings represent only a summary of the past.

Achondroplasia – A congenital disorder due to the conversion of cartilage to bone (frequently hereditary). Because of this, the growing ends or epiphyses, of the long bones of the limbs, are affected, and inadequate growth results in a type of dwarfism. Short well-porportioned body. Lordosis (curvature of the spine) often occurs, too.

SYMPTOMS:

Small size

Average achondroplastic attains a height of 50". Head is apt to be enlarged, although it appears relatively larger than it is because of small body size. Often bowing appearance to the legs.

Life expectancy is fairly normal.

HOSPITALIZATIONS AND TREATMENTS:

As they develop into middle life complications might possibly develop from their lordosis (abnormal curvature of the spine).

SPECIAL PROBLEMS NOTED AND RECOMMENDATIONS MADE BY DOCTORS:

Biggest problem is adapting to a world of "normal" size people and being able to function in a world made for "normal" size people. This affects schooling, socialization, and employment opportunities.

SUMMARY OF INFORMATION ABOUT CONGENITAL CARDIAC CONDITIONS (8)

For the general understanding of teachers or aides who might be working with a student with this disability, we have compiled a general summary from the records of the students at Human Resources School. This information represents a variety of findings, since each student has his own physician and may have attended different hospitals or rehabilitation centers.

Therefore, two important points must be noted. One is that each child is different, and so is the severity of his disability. The other is that medical procedures and recommendations are constantly advancing and changing, and these findings represent only a summary of the past.

Congenital Cardiac Conditions – born with a defect of the heart. This may involve a defect of the valves or it may involve the great vessels. Some of these can be corrected by surgical procedures.

SYMPTOMS:

In some heart conditions children have cyanotic or bluish coloring to lips and nail beds, caused by lack of oxygen in blood stream.

Shortness of breath following a period of exertion

Generally smaller in stature

HOSPITALIZATIONS AND TREATMENTS:

Correction of defect

Treatment of complications of defect

Treatment of severe respiratory infection which might cause difficulty in breathing.

Often hospitalized for procedure to improve condition of blood.

Examinations of the heart (eg., catheterizations) to define exact area of defect.

SPECIAL PROBLEMS NOTED AND RECOMMENDATIONS MADE BY DOCTORS:

More susceptible, probably to upper respiratory infections because of the way the body is affected by poor circulation and because of connection between heart and lungs.

Enlarged heart is common, because heart has to work twice as hard to accomplish its work.

Insufficiency of oxygen to brain may cause learning problems.

Problems related to circulation.

Extremes of temperature lower body resistance to infection. Therefore, air-conditioned building is better because temperature is more even.

May need to be more careful about overdoing.

Children with congenital heart disease are usually self-limiting in what they are able to do. This separates them from those who have an acquired heart disease and must be made to slow down and rest.

SUMMARY OF INFORMATION ABOUT HEMOPHILIA (9)

For the general understanding of teachers or aides who might be working with a student with this disability, we have compiled a general summary from the records of the students at Human Resources School. This information represents a variety of findings, since each student has his own physician and may have attended different hospitals or rehabilitation centers.

Therefore, two important points must be noted. One is that each child is different, and so is the severity of his disability. The other is that medical procedures and recommendations are constantly advancing and changing, and these findings represent only a summary of the past.

Hemophilia – Hereditary disorder transmitted by females but usually affecting only males. An abnormality in blood coagulation resulting in prolonged coagulation time and lowered prothrombin (clotting factor II) consumption.

SYMPTOMS:

Hemorrhage occurring either spontaneously or after trauma (injury)

Joint swelling

Ecchymotic areas of skin (discolored areas where blood has escaped into the tissue)

HOSPITALIZATIONS AND TREATMENTS:

Blood transfusions

Local hemostatis (arresting of escaping blood by means of compression or tying off blood vessels with ligature)

Administration of antihemophiliac globulin and albumin (plasma proteins).

SPECIAL PROBLEMS NOTED AND RECOMMENDATIONS MADE BY DOCTORS:

Avoidance of any trauma; precautions as far as activities are concerned.

Swimming only after consultation with physician and swimming instructor.

Physical Therapy (ROM) in some cases, but prohibited in others because of resulting hemoarthrosis.

ACTIVITIES AT HUMAN RESOURCES SCHOOL RELATED TO SOCIOLOGICAL HEALTH PROBLEMS

These sociological health activities were followed at Human Resources School during the course of the Health Education project. The curriculum activities incorporated into the sociological health modules were chosen after a reevaluation of these activities.

Importance of Drug Education to the Physically Disabled

Drug abuse and alcohol abuse have not been problems at Human Resources School. However, several special considerations made a program for drug education and drug abuse prevention very important for our physically disabled students.

Our students learn to drive in their senior year. Once they are able to drive, contact with sources of drug supply will be just as accessible to them as to the average mobile young person. Then, naïveté, pain, discomfort, frustration, boredom, or lack of ability to cope with problems might make them feel inclined to try drugs. They may also be more anxious for peer approval or more susceptible to peer pressure.

A number of physically disabled students take medication and need to understand the reactions possible from mixing drugs or alcohol with their medications. For students who are prone to respiratory problems, or cardiac or seizure disorders, or who take medications which affect the central nervous system, combinations of medications and drugs or alcohol constitutes a very special danger. As students on long-term medication get older they must also be aware that dosage and type of medication will probably change.

Drugs and alcohol would cause additional problems for the physically disabled in coping with their environment, and would aggravate problems in self-concept. The program aimed to make students aware of these possibilities so that they can make wise choices when they are in a position to do so.

A very close relationship among the parents, guidance counselor, physician and school nurse-teacher made possible a team approach to helping the students when a problem arises.

Involvement of Parents:

With severely disabled young people who may not ever be completely independent physically, the desirability of the involvement of their parents in either prevention or in helping with treatment became apparent to the health project team. A great deal was done to help the parents to help themselves and their children. Frequent small group meetings gave parents information and counseling from medical and psychological professionals or from representatives of social service agencies. The aim of the many parent-school contacts was to help the parents understand that, if they accept the responsibility for helping their children to develop socially, to make contact with the world, to develop creative interests and hobbies, and to prepare for employment, they are giving these young people a feeling of accomplishment and self-worth which would make drug use unnecessary.

Parents learned how they could cope with their children's disability. They saw that there can be joy and reward in coping. By seeing that other parents cope too, they became encouraged. They found that mutual parent support was a major benefit of school meetings and programs.

Drug Education Based on Mental Health Program:

This program built directly on the Mental Health program developed the previous year. Since drug education programs which focus only on information have not been found sufficiently effective, our program endeavored to help students to explore positive ways of fulfilling needs which might cause them to try drugs. It also provided activities whose objective was development of positive self-concept.

An atmosphere of trust and openness in small group sessions can help the students focus on their attitudes and behaviors and search for satisfying alternatives.

On the elementary level this was done by activities designed to help students in:

– learning to cope with feelings by
  using creative approaches
  analyzing why they do things
  discussing their fears and anger

– handling frustrations and solving problems appropriately

– recognizing one's own abilities by analyzing the many success experiences which have resulted because of the positive expectations inherent in the school program.

– communicating effectively through a wide variety of experiences in role-playing, play production, language skills activities, and peer-to-peer school programs with non-disabled students.

On the junior high level the activities focused on developing alternatives to the use of drugs and overcoming boredom and tension. Students explored programs of service to others, creative hobbies and recreational activities, learned how people reach higher levels of consciousness by studying world religions, or attending a seminar on some area of ethics, morality or philosophy, and invited experts to explain breathing and relaxation exercises, yoga, and transcendental meditation.

They also practiced assertiveness techniques to develop self-confidence and the ability to resist pressure from others.

On the senior high level, service to the younger students formed the basis for the drug education program. The example of the senior high school students at Human Resources School has been the most important single factor in building the self-concept of the younger children. The elementary school students see the older ones with similar disabilities coping with their environment, accepting responsibility for their own independence, offering service to the school and community, improving in physical status, and engaging in a multitude of academic and social activities. This encourages the younger ones to adopt a positive outlook on the future.

For this reason we accepted the offer of the seniors to participate in a preventive drug education program for the intermediate-grade students based on building their self-concept and helping them to realize that they do not have to do what someone else tells them to do in order to gain approval "just because they are handicapped."

Senior-Elementary Students' Drug Education and Self-Concept Building Program.

The senior high school students conducted a project with the intermediate elementary grade students consisting of the following:

I. Sharing factual information about each category of drugs: stimulants, depressants, hallucinogens, alcohol, deleriants, over-the-counter drugs and medications, and

   For each category answering the following questions:
   Why people take the drug
   The good and bad effects of the drug
   The legal penalties for drug offenses

II. Interesting them in finding out about their own medications and communicating with their physicians and parents about this as a first step in developing personal responsibility.

   After careful home preparation, students reviewed in groups:
   What medications they are taking, or have taken, and why.
   How that medication is helpful.
   The importance of taking the medication according to their physicians' directions.
   Whether there would be any problems in mixing their medication with other medications or with drugs or alcohol.

III. Encouraging them to know what their disability is and how drug abuse could make their problems worse.

IV. Helping them to develop personal responsibility.
   A. Seniors shared their experiences in coping with problems related to their disabilities.

B. Groups discussed ways of handling a situation when you do not want to do what someone is asking you to do, – including role-playing the handling of peer pressures to try drugs.

C. Individual rap sessions covered such topics as helping others, handling fears, anger, and boredom, accepting personal responsibility for yourself and your health.

Effects on Seniors

Each of these areas had to be throughly prepared by the seniors who did individual and group research; studied, reviewed, and rehearsed the facts that they were going to teach.

In the preparatory sessions they brought up questions which were followed up and answered by the school nurse-teacher and the physician about the side effects of each of the medications they themselves were taking.

In explaining the topics to the younger students the seniors demonstrated a sense of responsibility and commitment that impressed both the teachers and the younger students. Each group doubled the effect of the lessons on the other group.

New York State Curriculum is An Appropriate Basis:

Most of the topics covered in the New York State Curriculum in Sociological Health Problems are appropriate in some way for physically disabled students because these children with "normal" intellectual capacity need all the knowledge and guidance appropriate to other young people of their age. These topics and activities have been tried and accepted as appropriate throughout New York State.

Some special topics needed to be emphasized because of the necessity of coping with disability-related problems.

Because of the limitation of printing costs, those topics which are appropriate and do not need any special understanding on the part of either the teacher or student have been merely listed in the outline in the appendix. The teacher may refer to the New York State Health Education Curriculum (on Microfiche # ED 043 064 available from ERIC) or to the many recent pamphlets and multi-media aides for appropriate information on these topics.

All of the concepts, activities, and background information included in this module were coordinated with the New York State curriculum and are recommended by the health project committee as a result of the health curriculum activities in our school for three years.

EVALUATION

Ongoing evaluation and revision was done on each module.

The units included in each module are those evaluated by the teachers, students, and parents involved and given a rating of good (3), very good (4), or excellent (5), on the following items:

Relevance in fulfilling assessed needs

Helpfulness in improving students' health knowledge

Productiveness in establishing more positive attitudes

Motivation in developing good health habits

Evaluation of student learning was done by the students themselves by performance of the student self-evaluation activities. These activities gave each student the opportunity to demonstrate what he had learned in an enjoyable, non-competitive way.

The self-evaluation activities included in column three on each page are the ones rated good (3), very good (4), or excellent (5) by those who worked with them.

In addition, a student evaluation of the program indicates that both elementary and secondary students evaluated the project favorably. (See Tables 1 and 2) 45% of the secondary students were both modest and realistic in refusing to claim that their teaching would enable the elementary students to make a more mature decision about drugs, but 90% of the elementary students claimed that the secondary students had helped them by showing them that they could make a mature decision about taking drugs.

A majority (78% of the secondary students and 90% of the elementary students) agreed that the elementary students had acquired a great deal of new knowledge.

An additional evaluation of the beneficial effect on the secondary students was proven by the administration of the Gelolo Drug Knowledge Inventory. Their pre-test mean score was 53% and their post-test mean score was 76%.

Further indications of improvement were demonstrated on the standardized AAHPER Cooperative Health Education Test and the Health Behavior Inventory. These results are summarized in the final report.

TABLE 1

ELEMENTARY STUDENT EVALUATION OF DRUG EDUCATION PROGRAM

Name:_____ **Date:**_____

	Strongly Agree 5	Agree 4	Un-decided 3	Dis-agree 2	Strongly Disagree 1
1. They told me what I wanted to know	47%	43%	5%	5%	0%
2. They gave me the knowledge about drugs that I didn't have before	58%	32%	10%	0%	0%
3. They showed me that I can make a mature decision about taking drugs.	80%	10%	10%	0%	0%
4. I have now found out about any medicines I take or have taken.	37%	32%	10%	0%	0%

21% Do not take any medicine

TABLE 2

SECONDARY STUDENT EVALUATION OF DRUG EDUCATION PROGRAM

Name: _____ **Date:** _____

	Strongly Agree 5	Agree 4	Un-decided 3	Dis-agree 2	Strongly Disagree 1
1. We gave them information they didn't have before	78%	0%	22%	0%	0%
2. On the basis of our teaching, I think they can now make a more mature decision about drugs.	22%	22%	45%	11%	0%
3. I feel they would benefit by additional individual sessions	45%	33%	11%	11%	0%
4. I would like to do more individual teaching.	56%	22%	11%	11%	0%

Sociological Health Problems Modules

Grade 4-9

SOCIOLOGICAL HEALTH PROBLEMS

Special Topics in this Module	Objectives
4-9	
I. Developing a Positive Self-Concept	
A. Coping With Feelings	Learn to express and accept your own feelings.
B. Handling Frustrations and Solving Problems	Learn appropriate ways to handle frustrations and solve problems.
C. Recognizing One's Own Abilities	Recognize your own abilties.
D. Communicating	Improve your skill in communicating with others.
II. Smoking and the Health of the Disabled Student	Learn the effect of smoking which will cause harm to the disabled student.
7-9	
III. Developing Alternatives to the Use of Drugs	Develop alternative behaviors as a preventive for drug abuse.
IV. Developing Self-Confidence through Assertiveness	Develop assertiveness.

BACKGROUND INFORMATION 4-9

I. Developing a Positive Self-Concept

A. Coping with Feelings

General – Pre-adolescent children may not yet have a full awareness of their physical limitations or potential dependence, so they often view their situation with a certain degree of optimism that fades as they enter the teenage years. Since their lives tend to be self-centered it is important that they learn to understand the behavior of others. Each child can come to comprehend how he affects his classmates and in turn is affected by them. Students can grow to a better understanding of the frustrations their disabled schoolmates face and can learn how self-concept depends on both the individual and the people around him.

1. **Dysautonomia** – Many children must wear a Milwaukee brace for scoliosis (curvature of back) and most have speech problems which can cause them embarrassment.

2. **Spina Bifida** – Incontinence becomes a greater problem to pre-teenagers who are becoming concerned with their social acceptability. The constant attention necessary to keep odor from becoming offensive can be frustrating, and accidents happen in spite of careful care.

3. **Muscular Dystrophy** – Increasing muscle weakness curtails all activities more and more, along with making children depend on others for things they once did for themselves.

4. **Arthrogryposis** – The teenage preoccupation with bodily perfection magnifies self-consciousness about limb deformities for these children. Dependence on others for ADLs can be frustrating.

5. **Congenital Amputee** – The pre-teen years begin a period when youngsters become painfully aware of their bodies and are greatly upset by any deviation from perfection.

6. **Osteogenesis Imperfecta** – Children are still breaking bones frequently and spending periods in the hospital for bone surgery or fractures. Not only are they frustrated by the pain of fractures and the hospitalizations for surgery but they are confined at home in casts for long recuperative periods when they are dependent on family for their care. They have not had many positive experiences. Therefore, a positive self-concept may be lacking.

7. **Achondroplasia** – As their peers begin to experience growth spurts during the pre-teen years students can find their diminutive size setting them apart more and more from their peers.

8. **Congenital Cardiac Conditions** – Despite their muscular and skeletal ability to engage in stressful activities, children must adhere to prescribed restraints on their physical behavior. Feelings of inadequacy may develop, so alternate activities are important to help develop a positive self-concept.

9. **Hemophilia** – Boys face the constant fear of a bleeding episode and frustration from being left out of contact sports. It is important to interest them in more quiet activities which will channel some of their energies in a positive direction.

CONCEPTS	STUDENT ACTIVITIES	STUDENT SELF-EVALUATIONS
I. Developing a Positive Self-Concept **A. Coping With Feelings** **Objective:** Learn to express and accept your own feelings. 1. We can learn to express and accept our own feelings as well as those of others by: Creative work Analyzing why we do things Discussing our fears and anger.	1. Write a poem or a creative essay to describe your feelings about the most beautiful, most disappointing, most exciting or most boring thing that ever happened to you. 2. Explain why encounter groups help people to accept other people's feelings as being neither "good" nor "bad". Form a circle and let each one tell how he feels when: someone laughs at him no one listens to him no one chooses him. 3. Listen to the tone of voice and watch the facial expression of someone in your class when he is happy, when he is sad. How can you tell he is happy or sad? 4. Write down five things that you are afraid of and five things that make you angry. Choose a committee to make a list of the things most classmates are afraid of and feel angry about. Brainstorm for ideas about how to deal with the things on the lists. 5. Make a list of how you spoke and acted with each member of your family yesterday. Next to each incident try to tell why you spoke and acted as you did. Read your reasons aloud to the class group and see whether their viewpoints match yours.	1. Find a record of music that matches these feelings. Make a cassette of your voice reciting your poem while you play the music in the background. 2. All the members of the circle practice accepting the speaker's feelings without criticism. 4. Assign each class member to tell a younger brother, sister, or friend how to deal with being afraid or angry. Report to the class the next day about what advice they gave and how successful they were in helping the younger child. 5. Write a story about a friend of yours who has a problem, but do not finish it. Then pass the story on to a classmate to write the ending. Take back your story, see how well you agree with his ending, and discuss it with him. Read the best stories aloud for class discussion.

BACKGROUND INFORMATION 4-9

B. Handling Frustrations and Solving Problems

General – Disabled students often are not used to taking initiative. They don't know how to express preferences and don't have experience in expressing or asking for what they want.

A decision-making model – The more alternate ways a person can develop to satisfy needs constructively, the better frustrations can be handled. If a person has been using alcohol, for example, to avoid or forget his frustrations, teaching him the harmful effects touches only part of the problem. He also needs help in (1) identifying some of the sources of his frustrations and (2) acquiring skill in dealing with them in ways that enhance his feelings of

Two common responses of "normal" to "abnormal" people are revulsion (headwaiters "hide" you) and good luck bearers (people want to touch or give money). There is often an assumption that physically handicapped people are also mentally incompetent. People talk to their companion. They are treated as though they don't exist. There is also a myth that all handicapped are perpetually sweet and cheerful. Crippled children arouse great emotional responses in people because their vulnerability elicits a desire to care for them. But people expect adults to be sweet, etc., and find normal defenses objectionable. Then. they treat them as "invisible men". Thus disabled adults may develop a tendency to be defiant, to express themselves.

Help them accept themselves as they are. Help them to accept that the normal reaction is one of frustration. Teach them how to deal with it so they can live with themselves since they can't change the way it is. Make the best of the disability by emphasizing ability.

Examples of environmental frustration-reducing accommodations are:

1. considerations in the home that take into account the special needs of each person.
2. school curricula geared to individual and group differences
3. architectural features that fit varying physical attributes of people
4. legislation on behalf of persons with disabilities
5. social attitudes of acceptance, etc.

1. **Dysautonomia** – Parents may be less strict with their dysautonomic children and not want to frustrate them. Later in life the teenager will be faced with inevitable frustrations and will need to develop ways of coping with them.

The dysautonomic adolescent may develop various defense mechanisms. All defense mechanisms are acceptable, if they help an individual to function well. They are only bad if the adolescent becomes so completely unrealistic that the defense is being used in such a way that it interferes with function.

CONCEPTS	STUDENT ACTIVITIES	STUDENT SELF-EVALUATIONS
B. Handling Frustrations and Solving Problems. **Objective:** Learn appropriate ways to handle frustrations and solve problems.		
1. There are appropriate ways of handling frustration, problems, and boredom.	1. List appropriate and inappropriate ways of dealing with anger or frustration. Discuss the topic "Frustration May Lead to Disruption or Growth. How?" 2. Discuss what boredom really means: for example – need for attention; need for reassurance from parents; lack of leisure activities; lack of a plan for the future.	1. Discuss why each way would be an appropriate or inappropriate way of dealing with anger. 2. Make a list of activities you really enjoy. Make a list of other solutions to boredom. (ex. helping others) Write a paragraph on: "When I Feel Bored I Can _____".
2. Knowledge and application of problem-solving methods enable one to take a constructive approach and helps with decision-making for problems and frustrations.	1. Learn about the following methods of dealing with problems: a) **Direct Attack:** seeing the problem analyzing weaknesses and strengths working toward a goal achieving success b) **Detour:** change tactics or goals compensation – substitute another activity or satisfaction c) **Retreat – regression:** rationalization – alibis and excuses daydreaming – constructive escapism think about it and wait	1. Analyze the way you handled a problem you encountered recently.

BACKGROUND INFORMATION 4-9

3. Muscular Dystrophy – Frustrations and anger must be dealt with in non-violent ways since movement is severely restricted for the MD student. Let him use special devices such as "feeder arms" that work on a ball bearing joint for arm movement.

5. Congenital Amputee – Anger and frustration resulting from physical discomfort of prosthetic devices, corrective surgery, and physical therapy, as well as emotional strain of social acceptance, must be dealt with in a satisfactory way by the deformed child.

6. Osteogenesis Imperfecta – Dealing with frustration is very pertinent for the student with OI. Physically, he should be made as mobile as possible to get out frustrations. Physical problems, difficult as they may be, are felt to be easier to deal with than the problems and frustrations imposed by others: chronic curiosity and staring.

Anger may result in resentment. Need help with feelings of personal worth and achievement because of physical appearance being unattractive. For feelings of worth, practice attacking problems realistically, realizing what he cannot be because of physical limitations. Wheelchair basketball, weight-lifting – become possible for many other adolescents with OI.

7. Achondroplasia – Constant babying and being mistaken for a youngster can add frustration to that caused by limitations in height. People seem not to notice below eye level and thus don't notice them in crowds, on subways, etc. Thus the "outside world" can become a very frustrating place for people with diminutive stature.

8. Congenital Cardiac Conditions – Non-aggressive ways of coping with frustrations and anger must be found, since emotional upset or over-exertion could harm him physically. Constant limits on activities can be a source of such frustrations for children who appear normal and want to keep up with peers. The cardiac child who is not feeling limited by his condition may become very frustrated and angry when he is told he cannot do a particular activity.

9. Hemophilia – Have to learn how to deal with emotions. Since they shouldn't demonstrate anger by physical force or aggression, the need to channel aggressive feelings and verbalize more. Adolescent boys put more emphasis on athletics and feel an increased need to prove themselves. This may put more peer pressure on a hemophiliac. With growth at adolescence there seem to be more episodes of bleeding. There is sometimes brain damage from cerebral hemorrhage. Social effect – others might withdraw from contact with the hemophiliac for fear of causing injury by aggressive behavior or from lack of knowledge about the physical problems.

CONCEPTS	STUDENT ACTIVITIES	STUDENT SELF-EVALUATIONS
	2. Choose one problem you have and try to deal with it by following these steps in meeting problems constructively: a) recognize whether a real problem exists b) face the problem c) seek the cause d) decide upon a goal or course of action e) begin working in a positive way to carry out the plan for solving the problem. 3. Try to make a decision on a problem in which both alternatives are unattractive or both are really good by following these steps: a) State the problem b) Then list all the facts (provable) related to it c) See if any can be changed d) Draw a conclusion e) Carry out the conclusion f) If not successful, repeat steps, trying another conclusion.	2. Explain how you applied these steps in dealing with a problem related to (or caused by) your disability.

BACKGROUND INFORMATION 4-9

C. Recognizing One's Own Abilities

General – Emphasizing the fact that everyone has certain strong points and helping students to adopt a positive attitude by recognizing their own ability in an honest way substitutes positive for negative attidues.

Self-concept and self-image are also related to a student's academic achievement. Through individualized diagnostic and prescriptive teaching the school can help the disabled student begin at the instructional level and in areas at which he can achieve success. A success experience can reinforce the self-concept. Then, by using his strengths as a basis for remediating his weaknesses, the teacher can help the student to continue to succeed.

1. **Dysautonomia** – Emotional problems can be overcome with encouragement of good self-image. Encourage independence in the student in any way possible. He can be responsible for whatever treatment is necessary during the school day, e.g., IPPB therapy and breathing exercises. Let him schedule the day so the external environment can be more predictable than his own internal environment.

2. **Spina Bifida** – Often feels less adequate and experiences anxiety and depression. Focus his attention on his assets. Encourage as much independence as possible.

3. **Muscular Dystrophy** – During teen years there is a period of depression due to the awareness of the reality of their situation – (Duchenne Muscular Dystrophy is a progressive disease). Encourage independent activities for as long as is physically possible. Using a motorized wheelchair for independent mobility is a good boost for the student's ego and feeling of self-worth.

6. **Osteogenesis Imperfecta** – If they can walk around, they don't identify as disabled. However, those with very fragile bones are very small and immobile. During adolescence, fracturing occurs less often. Therefore the student's outlook improves. At this age there is less fear of new situations, which gives the student more incentive and ambition for exploration. The student's personality does not seem to be affected one way or another.

8. **Congenital Cardiac Conditions** – These students experience difficulty recognizing their abilities because during childhood they have been physically protected from many situations and not allowed much freedom. To the best of their physical capabilities, these students should be encouraged to do independent thinking and exploration.

9. **Hemophilia** – Some adolescent hemophiliacs whose parents are overprotective seem deliberately to engage in risky activities. It is misleading to speak of the hemophiliac as accident-prone. Rather, it is as if he boldly denies his illness and foolhardily courts disaster by repeatedly testing his vulnerability. Apart from the physical dangers, such rebellion generates tension and emotional strain. Although no definite cause-and-effect relationship has been demonstrated between emotional stress and increased bleeding episodes, the two are commonplace among hemophiliacs. Encourage involvement in program of self-infusion of the Anti-Hemolytic Factor which a teenage hemophiliac can handle and which gives them a new freedom and control of their situation.

CONCEPTS	STUDENT ACTIVITIES	STUDENT SELF-EVALUATIONS
C. Recognizing One's Own Abilities **Objective:** Recognize your own abilities.		
1. Recognizing one's own abilities helps one to appreciate one's own worth.	1. List all the abilities and good points you know about yourself. Form a small group and have everyone in the group tell you all the things they like about you.	1. Instead of rating yourself, rate your traits. Make a rating scale on which you evaluate your traits. Next to each one write one way to improve that trait. Then discuss this advice given by Albert Ellis: "Accept yourself, your aliveness, your existence, and determine to have as much joy out of life as you could possible have during this existence."
D. Communicating **Objective:** Improve your skill in communicating with others.		
1. Communication skills are important in learning to get along with others.	1. Role-play situations when you are faced with a problem or have to make a decision, or you are trying to impress someone, or get a point across to a friend who disagrees with you.	1. Rehearse your answer to a person who asks you a question about your disability. 2. Form committees to practice your communication skills: a) in a telephone conversation. b) meeting someone for the first time. c) explaining to a friend that you disagree with his point of view. d) telling someone what you like about him.

II. **Smoking –**

General – Children with disabilities affecting their respiratory system should not smoke.

1. **Dysautonomia** – These children have increased secretions in their lungs. Also, many of these children develop scoliosis which can cause the organs in the chest to be displaced thus reducing the lung capacity. These children breathe less automatically because of the dysfunctioning autonomic nervous system.

3. **Muscular Dystrophy** – These children have poor muscle power of their respiratory system and smaller lung capacity due to their poor muscle mobility. Coughing is weak. Therefore foreign matter or mucus is difficult to remove. Smoking increases the heart rate, thus making the heart work harder.

8. **Congenital Cardiac Conditions** – These children should omit smoking because of the damaged heart which, if further insulted by nicotine (by increasing the heart rate) will wear out sooner. Circulation is poor for children with cardiac problems and nicotine constricts the blood vessels which would further reduce circulation, especially in the extremities.

CONCEPTS	STUDENT ACTIVITIES	STUDENT SELF-EVALUATIONS
II. Smoking and the Health of the Disabled Student **Objective:** Learn the effects of smoking which will cause harm to the disabled student.		
1. Smoking can be hazardous to the health of a disabled person.	1. Invite the school physician, SNT, or an Inhalation Therapist to discuss the effects of smoking on specific disabilities. Ask him to explain the use of the I PPB machine. 2. View the filmstrip "The $50,000 Habit" and discuss how people get started smoking. 3. Investigate the many programs for smokers who wish to break the habit.	1. Explain how smoking affects the nervous system, the digestive tract, the heart, the lungs, birth weight of babies. 2. Discuss the rights of non-smokers. 3. Write to the American Heart Association for pamphlets about the effects of smoking. Give them to any members of your family who smoke, and discuss them. Suggest the following behavior modification techniques to a person who is trying to stop smoking, and offer to help him follow them. a. Identify the times or circumstances (stimuli) when you want to smoke. b. Count the number of times, the number of cigarettes, etc. and write it down. c. Wrap up the cigarette pack in a chart and rubber band, and each time you smoke write down the time, circumstances, etc. on the chart. d. Get the support of friends to help you avoid smoking. e. Develop other (alternative) things you can do instead of smoking. f. Reinforce (reward) yourself in some set way every time you resist the impulse to smoke.

CONCEPTS	STUDENT ACTIVITIES	STUDENT SELF-EVALUATIONS
	4. Debate the many programs and evaluate their effectiveness.	4. Do an independent study on the possible effects of smoking on one of the following: emphysema chronic bronchitis congenital cardiac conditions dysautonomia muscular dystrophy
	5. Ask an adult who smokes regularly to come to class to have his pulse taken. Then invite him to leave the building and smoke a whole cigarette. Ask him to return to have his pulse taken again. Then discuss how chain smoking, which does not give the pulse a chance to return to normal, would put stress on the heart.	

III. Developing Alternatives to the Use of Drugs

General – Disabled children experience more frustration than is normally expected during the teenage years. Like all teenagers, they enter into a period of preoccupation with bodily perfection where anything short of movie star quality is unbearable. Their childhood years of restricted activity and parental protection are added to a normal desire for independence and involvement outside the home. Resistence to peer pressure is low since self-confidence is often lacking. Drugs, smoking and alcohol can be a rebellion against protective parents, a tension release for physical problems, or a means of gaining peer acceptance.

1. **Dysautonomia** – Back braces and speech problems embarrass these students who are already set apart from their peers by their physical state. They worry about uncertain sexual potential, and decreased sensation can be frustrating for them.

2. **Spina Bifida** – Interest in the opposite sex during the teenage years compounds the problems of inadequacy. Boys may worry about their ability to "perform" sexually and often cannot join in discussions about experiences they've had. Girls may also be unsure of their ability to engage in sexual acts. Both sexes will benefit from discussions about teenagers' tendencies to spread misinformation and magnify stories out of proportion, since they may not be quick to pick up falsehoods when peers discuss sexual experiences.

CONCEPTS	STUDENT ACTIVITIES	STUDENT SELF-EVALUATIONS
III. Developing Alternatives to the Use of Drugs **Objective:** Develop alternative behaviors as a preventive for drug abuse. 1. There are many enjoyable experiences which could serve as alternatives to drug use and overcome boredom or tension.	1. Choose one of the following "alternative experiences" and make a plan to learn about or participate in a program of: Social service – helping the poor, aged, or young Political service – writing letters or lobbying for a non-partisan project. Discuss how each of the following could provide intellectual excitement: reading creative games or puzzles training in concentration memory training Learn how people reach higher levels of consciousness: study world religions for a social studies project watch a prayer meeting or crusade on TV attend a seminar, course, or symposium on some areas of ethics, morality or philosophy. 2. Invite experts in each of the following to discuss the how and why of: Breathing and relaxation exercises Yoga Transcendental Meditation	1. Each week try out one of each of the following creative or athletic activities: exercise games a hobby or craft a team a club gardening singing dramatics writing

3. **Muscular Dystrophy** – The teenage years often bring on a period of emotional depression for these students. Contributing factors are concern for the future, awareness of their deteriorating condition, inability to keep up with peers and increasing dependence on family in spite of urges for independence.

4. **Arthrogryposis** – Slightly deformed limbs can be embarrassing to students who want to be as much like their peers as possible. Those with limited arm movement will be unable to care for their hair and complexions, which can be very frustrating if an acne condition develops.

5. **Congenital Amputee** – The teenage preoccupation with physical appearance magnifies deformities and prosthetic devices in students' eyes. Both they and their peers are painfully aware of any deviation from the norm, so self-image can be quite poor at this time.

6. **Osteogenesis Imperfecta** – Years of hospitalization and confinement finally end as the condition begins to stabilize. Students can engage in formerly forbidden activities but must still exercise some caution. Small stature and deformed limbs are a source of embarrassment for the teenager.

7. **Achondroplasia** – Students may find their diminutive size becoming more and more obvious as peers grow rapidly into "normal" manhood and womanhood. They may be taken for children repeatedly during these years when approaching adulthood is so important.

CONCEPTS	STUDENT ACTIVITIES	STUDENT SELF-EVALUATIONS
2. Since recreation promotes relaxation and fitness, recreational activities and hobbies can be developed to provide present and future emotional and physical well-being.	1. Investigate two of the following hobbies and report to the class on the basic knowledge and equipment needed for a beginner. Tell what clubs or groups having this hobby could be attended or contacted by mail. Hobbies and recreational activities to investigate: art media – painting, ceramics printing checkers, chess collecting – stamps, coins, flags photography creative writing reading stargazing bird watching knitting crewel crocheting embroidering rug making flower arranging	
IV. Developing Self-Confidence through Assertiveness. **Objective**: Develop assertiveness.		
1. Assertiveness can help you resist pressure from others.	1. Invite a psychologist to discuss the following reasons why people try drugs: – Depression – Inability to cope – Nothing better to do – Peer pressure – Force – Curiosity	1. Rate your self-confidence and assertiveness by following these suggestions. To practice your answers to a friend who gives you many reasons why you should try a drug he is using, role-play with a classmate. A. Find some point on which you can say something agreeable. B. Calmly state your decision about not trying it. C. Refuse to be insulted or intimidated by his questions or his replies. D. Suggest some alternatives he could try.

8. Congenital Cardiac Conditions – At an age when they want to participate in group sports and excel in a popular activity students are often restricted by their condition.

9. Hemophilia – Boys are constantly frustrated by curtailment of their activities and episodes of bleeding that occur despite precautions. They may feel inadequate physically when compared to muscular heroes favored by their peers.

Parent Involvement

With severely disabled young people who may not ever be completely independent physically, the desirability of the involvement of their parents in either prevention or in helping with treatment is very great. A great deal must be done to help the parent. Frequent small group meetings can give parents information and counseling from medical and psychological professionals or from social service agencies. Parents often need help in understanding that, if they can accept the responsibility for helping their children to develop socially, to make contact with the world, to develop creative interests and hobbies and to prepare for employment, they are giving these young people a feeling of accomplishment and self-worth which would make drug use unnecessary.

CONCEPTS	STUDENT ACTIVITIES	STUDENT SELF-EVALUATIONS
	2. Practice disputing the following irrational beliefs. Tell why *should, ought,* and *must* are regarded as irrational by Albert Ellis. a) You *must* be loved by everyone. b) We must be perfect, complete, and adequate in all we do. c) People who upset us are *bad.* d) Things are terrible, catastrophic and horrible when they don't go your way. e) Happiness is externally caused: dispute, Erase *shoulds, oughts, musts.*	

Sociological Health Problems Modules

Grade 10-12

SOCIOLOGICAL HEALTH PROBLEMS 10-12

Special Topics in this Module	Objectives
I. Sharing and Service to Others through a Combined Drug Education Project	
A. Sharing Factual Information About Drugs and Alcohol with Younger Students	Share facts about drugs and alcohol with younger students.
B. Explaining Possible Reactions from Mixing Medications with Drugs or Alcohol	Explain the importance of knowing what medications you are taking, their effect on your body, and possible complications if mixed with another drug or alcohol.
C. Teaching How Drug Abuse Could Increase Disability Problems	Teach younger disabled students how drug abuse could increase disability problems.
D. Helping Younger Students to Develop Personal Responsibility	Help younger students to develop personal responsibility.

BACKGROUND INFORMATION 10-12

I. Sharing and Service to Others through a Combined Drug Education Project

General – A knowledge of the student's own medications and the potential health hazards created by indiscriminate use of other drugs including alcohol while taking their prescribed medications is important.

Examples of a few medications dispensed at HRS by the School Nurse-Teacher under Physician's direction:

Diapid Nasal Spray – replacement for adrenal cortical hormone in Addision's Disease; after neurosurgery for brain tumor (Post brain tumor).

Maalox – anti-acid, soothes, neutralizes gastric irritation. (Post brain tumor; gastric ulcers)

Mestinon – derivative of prostigmin – makes dysautonomics less dizzy; the hope is that it stimulates the autonomic nervous system that isn't functioning. (Dysautonomia)

Phenobarbital – sedative. (seizure disorders)

Zarontin – liquid anti-convulsant. (seizure disorders)

Dilantin – anti-convulsant – acts as a sedative.

Vitamin C – to keep acidity level higher in urine – controls bacterial level; also promotes healing. (Spina Bifida)

Valium – tranquilizer to control spasms.

Ritalin – has paradoxical effect on children of tranquilizing. Dosage may have to be changed because effectiveness lessens. (Hyperactivity)

Tridione – anti-convulsant – given in combination, depending on number of seizures, etc. (Seizure disorders)

Bufferin – buffered aspirin – relieves pain and inflammation in joints. (entericoated aspirin – delays absorption process) (Rheumatoid Arthritis)

Urecholine – assists in urinary function; may have effect on autonomic system. (Dysautonomia)

Mandelamine – anti-biotic for prevention of infection – specific for urinary tract infection. (Spina Bifida)

Tegretol – to control uncoordinated movements (Dystonia)

Keflex – broad spectrum anti-biotic. (Spina Bifida and Spinal Atrophy)

CONCEPTS	STUDENT ACTIVITIES	STUDENT SELF-EVALUATIONS
I. Sharing and Service to Others Through a Combined Drug Education Project A. Sharing Factual Information about Drugs and Alcohol with Younger Students **Objective**: Share facts about drugs and alcohol with younger students. B. Explaining Possible Reactions from Mixing Medications with Drugs or Alcohol. **Objective**: Explain the importance of knowing what medications you are taking, their effect on your body, and possible complications if mixed with another drug or alcohol. C. Teaching How Drug Abuse Could Increase Disability Problems **Objective**: Teach younger disabled students how drug abuse could increase disability problems D. Helping Younger Students to Develop Personal Responsibility **Objective**: Help younger students to develop personal responsibility	1. Form a panel to explain to an intermediate age group the following facts about each category of drugs: a. why people take that drug b. the good and bad effects of the drug c. the legal penalties for drug offenses Assign these activities to your group and review the answers on the following day: 2. Answer questions on the above topics about each of these categories: stimulants depressants hallucinogens alcohol over-the-counter drugs or non-prescription drugs deleriants	1 & 2. Find out: a. what medication you are taking or (have taken) b. why you are taking (or have taken) that particular medication. c. how it helps you d. what possible side effects might be experienced while taking the medication e. what possible effects could result from combining this medication with any other medication f. what problems might result from mixing your medication with alcohol.

BACKGROUND INFORMATION 10-12

Complications result from mixtures of the following drugs:

Phenobarbitals
Anti-convulsants
Those used to control movement
Anti-depressants
Any that affect the Central Nervous System – Drugs that affect the central nervous system affect all of the body – even though given for a specific problem.
Alcohol

For students who are prone to respiratory problems or cardiac or seizure disorders, or who take medications which affect the central nervous system, combinations of medications and drugs or alcohol constitute a very special danger.

As students on long-term medication get older they must also be aware that dosage and type of medication will probably change.

CONCEPTS	STUDENT ACTIVITIES	STUDENT SELF-EVALUATIONS
1. Senior high school students with physical disabilities can help younger students by: a. telling them facts about drugs, alcohol, and medicines b. explaining what their disabilities are and how they cope with them. c. helping them build self-confidence by assertiveness training and by rap sessions, telling them they don't have to do or think what others tell them just because they're disabled.	See previous page for activities 1 & 2 3. Discuss reasons for having knowledge and understanding of your own medication and reasons for proper use of medications according to your doctor's recommendations. 4. Discuss the effects of a – mixing drugs b – mixing alcohol and drugs c – mixing alcohol and medication d – mixing drugs and medication 5. Role-play ways to handle a situation when you don't want to do what someone is asking you to do. Act out ways of handling an unreasonable request. Debate: Are other people responsible for you? 6. Carry a prescription or doctor's note with your medication to prove they are prescribed – in case you are stopped for a traffic infraction or any problems with law enforcement agencies. 7. Explain your disability to the younger students in factual, objective terms. Answer their questions. Explain how drug abuse could be a serious health hazard.	3. Discuss the precautions about taking medications at home or school. 4. Discuss why you should carry the prescription label with you whenever you carry the medication. 5. Find out what your disability is and how drug abuse could make your problems worse. 6. In individual rap sessions discuss any of the following topics: a. What *do* you do to help other people? (parents, brothers, sisters, friends, etc.) b. What *could* you do to help other people? c. What are some things you are afraid of? d. What can you do about them? e. What are some things that make you angry? f. How do you deal with angry feelings? g. What can you do when you're bored? h. Are other people responsible for you?

Appendix

APPENDIX

The following are the topics covered in the New York State Curriculum (See ERIC # ED 043 064) and recommended as a starting point for all physically disabled students. Topics requiring special background information and/or special concepts have already been covered in the modules.

Alcohol Education

Grades 4-6

I. Nature of Alcohol
- A. Definition and properties
  - 1. Ethyl alcohol
  - 2. Methyl alcohol
- B. Vitamins
- C. Calories
- D. Glandular action
- E. Manufacture of alcohol
- F. Industrial – Commercial alcohol is poisonous
- G. Commercial uses of alcohol in food and medical products, flavoring, solvents, medicines, antiseptics
- H. Medicinal uses

II. The Use of Alcohol in the Early Days in America
- A. Colonies
  - 1. Virginia
  - 2. New England

III. Alcohol in the Human Body
- A. Absorption
  - 1. Stomach
  - 2. Small intestines
  - 3. Bloodstream
    - a. Transport
    - b. Oxidation
    - c. Effect on systems
      - (1) Nervous
      - (2) Circulatory

IV. Elimination

V. Alcohol and Problems

VI. Alcohol and the Family
- A. Attitudes are learned
- B. Economic Aspects

Drugs and Narcotics

Grades 4-6

I. Early Man's Use of Drugs
- A. Magical Relationship
- B. Pain relievers
- C. Lasting Value of Some Early Drugs
- D. Drugs – Helpful or Harmful

II. Modern Drugs and Their Contributions
- A. Disease
  - 1. How drugs function
  - 2. Effects of drugs

III. The Use and Misuse of Drugs
- A. Types of Drugs
  - 1. Prescription drugs
  - 2. Nonprescription drugs
- B. The proper use of drugs
  - 1. Directions
  - 2. Storage
  - 3. Usage

Smoking and Health

Grades 4-6

I. Your Decision About Smoking
- A. Important considerations
  - 1. Effects of smoking on one's health
    - a. Content of smoke
    - b. Physiological effects
  - 2. Effects of smoking on physical performance

3. The expense of smoking
4. The smoking habit may last your entire life-time
5. Safety implications of smoking
6. Attitudes of parents and other family members
7. Uniqueness of the individual

B. Making the right decisions
1. A mature decision based on a clear understanding of tobacco and its use
2. The extent to which a person is "grown up" is not measured by his decision to smoke

II. Man's Use of Tobacco
A. Early use of Tobacco (1492–1600)
1. American Indians
2. Canadian Indians
3. Natives of Mexico and Central America
4. Europe (Middle 1500)

B. The Middle Period
1. English Colonies in America

C. Recent History (1800–Present)
1. Expansion of the industry
2. Increased use of cigars and cigarettes
3. Era of Tobacco Reform (1895–1921)
a. Many states banned the sale of cigarettes
b. Legal measures had no lasting influence
4. The Modern Tobacco Era
a. The United States is a world leader in tobacco
(1) Production
(2) Exportation
(3) Consumption
b. Certain of our states base a large portion of their economy on tobacco industry

III. Tobacco and Health
A. Cause for concern in recent years
1. Increase in heart disease
2. More deaths due to lung cancer
3. Shortened life expectancy of smokers

B. Increased tobacco use in the United States
1. Per capita cigarette consumption increased since 1900
2. Corresponding increase in incidence of lung cancer and other cardio-respiratory illnesses
3. Consumption of pipe tobacco and cigars has decreased
4. Smoking by teenagers has increased

C. Surgeon General's Report
1. Report made in 1964
2. Research findings
a. Cigarette smoking is a cause of lung cancer
b. The incidence of heart disease is higher among smokers than nonsmokers
c. Other respiratory diseases are more common among smokers

D. Tobacco and Youth
1. Effects on the respiratory system
a. Interferes with normal breathing
b. Athletes are instructed not to smoke
c. Tendency toward more frequent colds of longer duration
2. Effects on the digestive system
a. Smoking tends to reduce one's appetite
b. Interferes with the ability to taste and enjoy food
3. Effects on heart
a. Smoking increases heart rate
(1) Disadvantages to the athlete
(2) Affects efficiency of body muscles
4. Growth and development
a. Decreases the desire for food
b. Deprives body of fresh air necessary for the growth of tissue

IV. Deciding About Smoking

Grades 7, 8, 9

Smoking and Health

I. The Advertisement and Promotion of Tobacco

II. Developing the Smoking Habit

III. Physiological Effects of Tobacco

Alcohol Education

I. The Adolescent and Beverage Alcohol

II. The Use of Alcohol in the United States

III. The Social Problems Associated with Beverage Alcohol

IV. Legislative Control and Economics of Alcohol

Drugs and Narcotic Education

I. The Development of Modern Drugs

II. Prescription Drugs

III. Nonprescription Drugs (Over-the-Counter Drugs)

IV. Safeguarding Drugs and Their Use

V. The Historical Use of Drugs

VI. Habit Forming and Addicting Drugs

Grades 10, 11, 12

Smoking and Health

I. Attitudes Toward the Use of Tobacco

II. Psychosocial Factors Related to Tobacco Use

III. Smoking Research and Reports

IV. Smoking Among High School Students

Alcohol Education

I. Alcohol and Mental Health

II. Physiological Effects of Alcohol

III. The Psychological Effects of Alcohol

IV. Alcoholism

V. Other Disease Forms Associated With Alcoholism

VI. Rehabilitation and Treatment

VII. Research Agencies and Prevention of Alcoholism

Drugs and Narcotic Education

I. Addiction and Habituation

II. The Narcotic Drugs

III. Marijuana

IV. Stimulants

V. Drug Traffic

VI. Legislation

VII. Rehabilitation of the Addict

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Commercial Organizations – such as, publishers and manufacturers of audio-visual learning aids.

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ANNOTATED BIBLIOGRAPHY FOR SPECIFIC DISABILITIES

AMYOTONIA CONGENITA

Muscular Dystrophy Associations of America. Oppenheim's Disease or Benign Congenital Hypotonia Fact Sheet. New York (1970 Broadway): Author, n.d. 3 pages.

Brief description of the causes, symptoms, inheritance pattern, and progression of Oppenheim's disease, which causes the muscle weakness known as the amyotonia congenita syndrome. Covers medical treatments and research. Offers local MDAA offices as sources of additional information.

Muscular Dystrophy Associations of America. Werding-Hoffman Disease or Infantile Spinal Muscular Atrophy Fact Sheet. New York (1970 Broadway): Author, n.d. 3 pages.

Same format as the MDAA fact sheet on Oppenheim's Disease. General information on Werding-Hoffman disease, which also causes the amyotonia syndrome. Offers local MDAA offices as sources of additional information.

ARTHRITIS

U.S. Department of Health Education, and Welfare. Arthritis. Washington, D.C.: U.S. Government Printing Office, 1968. 6 pages. $ .05 per single copy.

Brief historical description of research and treatment related to rheumatoid arthritis, osteoarthritis, and gout. General information on causes and symptoms of the disease. Includes sources of additional information.

BIRTH DEFECTS

National Foundation – March of Dimes. Birth Defects. White Plains, New York (P.O. Box 2000): Author, n.d. 14 pages.

Simple statistical information on the prevalence of common birth defects in the United States and on those which appear after birth. Description of hereditary and environmental influences, prevention, and treatment.

CEREBRAL PALSY or SPASTIC PARAPLEGIA

Seaver, Jacqueline. Cerebral Paley – More Hope Than Ever. New York (381 Park Ave.): Public Affairs Committee, 1969. Pamphlet # 401. 27 pages. $ .25 per single copy.

General information on the causes and symptoms of cerebral palsy. Covers special problems related to the disability, child development, and employment. Describes treatment and research.

United Cerebral Palsy Associations. Realistic Educational Planning for Children With Cerebral Palsy. New York (66 E. 34 St.): Author, n.d. 24 pages. & .25 per single copy.

A source of information and guidance for school personnel involved in the psychological evaluation of cerebral palsied children. Coverage includes problems in the administration and interpretation of standardized tests. A bibliography of suggested reading is included.

CHARCOT-MARIE-TOOTH DISEASE

Muscular Dystrophy Associations of America. Charcot-Marie-Tooth Disease or Peroneal Muscular Atrophy Fact Sheet. New York (1970 Broadway): Author, n.d. 3 pages.

Brief information on Charcot-Marie-Tooth disease, presented in the same format as the MDAA fact sheets on amyotonia congenita. Offers local MDAA offices as sources of additional information.

DYSAUTONOMIA

Dysautonomia Association. Educating the Child With Familial Dysautonomia. Brooklyn, New York (32 Court St.): Author, 1967, 15 pages.

A practical guide to help parents deal with the educational lives of their dysautonomic children. Includes information on testing, expectations, relations

ANNOTATED BIBLIOGRAPHY FOR SPECIFIC DISABILITIES (continued)

DYSAUTONOMIA (continued)

with teachers, parents' role in schooling, and different types of schools.

Riley, C. M. Living With A Child With Familial Dysautonomia. Brooklyn, New York (32 Court St.): Dysautonomia Association, 1956, 40 pages.

Detailed information for parents of dysautonomic children. Coverage includes a description of the autonomic nervous system as it is affected by the condition, management of dysautonomic children, heredity, genetics, and research.

HEART DISEASE

American Heart Association. Children With Heart Disease: A Guide for Teachers. Mineola, New York (365 Willis Ave.): Author, 1971, 15 pages.

Presents a general description of the symptoms, hospitalizations, and treatments faced by children with rheumatic fever or congenital heart defects. Suggests practical ways of dealing with absences and the question of vocational counseling. Gives sources of help for medical services and includes a bibliography of teaching aids.

HEMOPHILIA

National Hemophilia Foundation. The Hemophiliac and His School. New York (25 W. 39 St.): Author, n.d. 7 pages.

A source of information for school personnel who deal with Hemophiliac children. Coverage includes symptoms, prevention of injury, and treatment in emergencies. Suggests local NHF chapters as sources of additional information.

National Hemophilia Foundation. New Perspective on Hemophilia. New York (25 W. 39 St.): Author, n.d. 6 pages.

HEMOPHILIA (continued)

Brief coverage of the symptoms and genetic pattern of inheritance of hemophilia, the latter shown traced through British r yalty. Description of the work done by the National Hemophilia Foundation.

National Hemophilia Foundation. Psychological Aspects of Hemophilia. New York (25 W. 39 St.): Author, n.d. 14 pages.

Presentation of the problems of overprotection, bleeding and emotions, adaptation, risk from action, maturity, discipline, hospitalizations, treatments, and family relations. Includes a bibliography for additional information.

Vogel, James M. How to Live With Hemophilia. New York: Interbook Incorporated, n.d.

Written by a physican to explain details to be considered in the activities of daily living of the hemophiliac. Contains clear explanation of the blood factors involved and of the heraditary aspects of the disease.

KUGELBERG-WELANDER DISEASE

Muscular Dystrophy Associations of America. Kugelberg-Welander Disease or Juvenile Spinal Atrophy Fact Sheet. New York (1970 Broadway): Author, n.d. 3 pages.

Brief information on Kugelberg-Welander disease, presented in the same format as the MDAA fact sheets on Amyotonia Congenita. Offers local MDAA offices as sources of additional information.

MUSCULAR DYSTROPHY

Muscular Dystrophy Associations of America. Muscular Dystrophy Fact Sheet. New York (1970 Broadway): Author, n.d. 3 pages.

ANNOTATED BIBLIOGRAPHY FOR SPECIFIC DISABILITIES (continued)

MUSCULAR DYSTROPHY (continued)

Brief information on Muscular Dystrophy, presented in the same manner as the MDAA fact sheet on Amyotonia Congenita. Offers local MDAA offices as sources of additional information.

Muscular Dystrophy Associations of America. Patient and Community Services Program. New York (1970 Broadway): Author, 1973, 19 pages.

Detailed description of MDAA services such as testing and diagnosis, therapy, innoculations, transportation, and recreation. Lists services authorized for payment and criteria for eligibility. Includes a listing of MDAA clinics throughout the United States.

PARAPLEGIA

Bundy, Kathryn. What You Should Know About Paraplegia. Adapted from "An Introduction to Paraplegia" by William H. Edward. Washington, D.C.: U.S. Government Printing Office, n.d. 12 pages. $ .25 per single copy.

Written as a practical guide to the new life faced by a paraplegic adult, but presents information valuable to teachers or parents as well. Deals with problems like toileting, skin sores, care of feet, rehabilitation, and sex.

SPINA BIFIDA

Swinyard, C. The Child With Spina Bifida. New York (345 E. 46 St.): Association for the Aid of Crippled Children, 1971. 20 pages.

A general guide for parents, presenting symptoms, causes, treatments, and special problems. Includes clear, simple illustrations. Gives addresses for obtaining translations in nine languages.

SPINA BIFIDA (continued)

Bruce, Margaret, & Veigh, Gretchen. A Practical Guide for Parents of Children With Myelomeningocele. Pittsburgh, Pennsylvania: Allegheny County Easter Seal Society for Crippled Children and Adults, 1972. 32 pages. $2.00 per single copy. *NOTE:* Order directly from Gretchen Veigh, 1065 Findley Dr. E., Pittsburgh, Pa.

A detailed treatment of spina bifida, including numerous topics such as brace adjustment, diet, clothing, medications, exercises, education, and family relations. Illustrated with clear sketches. Included is a glossary of medical terms.